

Hospital Fined for Failure to Provide Emergency Care

Kathleen Ream, Director of Government Affairs

A California hospital was ordered by the US Department of Health and Human Services Office of Inspector General (OIG) to pay a penalty of \$50,000 for failing to provide required emergency care for a patient who died in the emergency department (St. Joseph's Medical Center v. OIG, Departmental Appeals Bd., Civil Remedies Div., Dec. No. CR1895, 1/30/09).

In a January 30, decision, Administrative Law Judge (ALJ) Steven T. Kessel – Departmental Appeals Board, Civil Remedies Division – sustained the OIG's determination that St. Joseph's Medical Center in Stockton, California, violated EMTALA by failing to provide a medical screening examination and stabilizing treatment for the patient. The OIG issued a press release to highlight the fact that St. Joseph's pursued litigation before an ALJ, which is a relatively unusual situation.

In the decision, the ALJ stated that the failure to provide the patient with a screening examination was "shocking" in light of the facts that were known to St. Joseph's staff the night the patient died. He also noted that the events that took place on December 29, 2001, show that St. Joseph's staff "botched horribly" the care they gave to the patient. "This case demonstrates that OIG will impose the maximum civil monetary penalty for egregious violations of the requirements of EMTALA," HHS OIG Daniel R. Levinson said.

The patient was brought to the hospital's emergency department (ED) by members of his family. After waiting about an hour and a half, the triage nurse checked the patient, but was unable to take his temperature because his tongue was swollen. However, the triage nurse classified the patient as "routine" and sent the patient back to the waiting room. The patient's condition appeared to deteriorate, and an hour later, a family member notified the nurse that he might be having a heart attack.

The emergency department charge nurse instructed a technician to put the patient on a cardiac monitor and to administer oxygen, but the instructions were not followed. After another half hour, the patient demonstrated serious breathing problems, but when a medical team arrived, the patient was in full cardiopulmonary arrest, and the team was unable to resuscitate the patient, who died an hour later.

The ALJ was not persuaded by St. Joseph's argument that EMTALA is not a federal malpractice statute that makes hospitals liable for all negligence committed in emergency rooms. The ALJ determined that the evidence supported a conclusion that the hospital's staff grossly neglected the patient's needs and failed to provide him with a screening examination even after being told that the patient was having difficulty breathing.

Judge Kessel wrote, "EMTALA does not excuse a hospital for failing to perform a screening examination where that failure is the consequence of the hospital's staff's gross negligence. EMTALA is unequivocal. A hospital must provide a screening examination to every individual who comes to its emergency department requesting treatment. There is no 'negligence' exception to the law."

He determined that the evidence proved that St. Joseph's manifested a high level of culpability for its neglect of the patient and also found additional evidence that underscored both the hospital's culpability and the seriousness of its EMTALA violation. The ALJ also found that the person performing triage on the patient was not qualified – under St. Joseph's own criteria – to perform triage.

"This may have been the first instance of an EMTALA violation by [St. Joseph's]," the ALJ concluded. "But, if so, it is so egregious as to merit a maximum civil money penalty in and of itself."

HHS Announces Stimulus Funds for Hospitals Serving the Poor

On March 20, 2009, the US Department of Health and Human Services (HHS) announced the availability of \$268 million in funds under the economic stimulus law to hospitals that treat large numbers of low-income or uninsured patients.

The funds are available to so-called DSH hospitals, which treat a disproportionate share of the poor. The stimulus law increases funding for DSH facilities from \$11.06 billion to \$11.33 billion in 2009. States will have to show that they have exhausted their existing DSH allotments before they can gain access to the added funds.

"Thousands of hospitals around the country are the first place many families take their sick children for care or the only place where some of the more than 45 million uninsured Americans can receive some form of health care," said Acting HHS Secretary, Charles E. Johnson. The funding "will help ensure hospitals can keep their doors open to the people who need care most."

Larry S. Gage, president of the National Association of Public Hospitals, issued a statement thanking the administration and Congress for the funds. "Public and other safety net hospitals in communities across the country are reporting increases in uninsured care of between 10 and 20 percent depending on where they are located," Gage said.

US Healthcare System Fails Youth

According to a recent report from the National Research Council and the Institute of Medicine, the US healthcare system often fails adolescents age 10 to 19. The report found that adolescents, more than any other age group, rely on hospital EDs for routine treatment. In addition, many youths lack access to specialty services for mental health, substance abuse and sexual and reproductive health – this despite the fact that while most US adolescents are healthy, many engage in risky behavior, from binge drinking to carrying weapons, and have physical and mental conditions that can ultimately be harmful. "Even when services are accessible, many adolescents may not find them acceptable because of concerns that confidentiality is not fully ensured, especially in such sensitive domains as substance use or sexual and reproductive health," the authors said. To address their findings, the authors recommend that government, private foundations and insurers promote a coordinated healthcare system that seeks to improve care for adolescents and that lawmakers develop plans to ensure comprehensive health coverage.

These recommendations may be pursued next month when Democrats in Congress plan to renew their efforts to add four million youngsters to the State Children's Health Insurance Program (SCHIP). The legislation was vetoed twice by President Bush last year, but President Obama supports an overhaul of the healthcare system that would expand subsidies for health insurance and make coverage of all children mandatory.

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Study Portrays ED Crowding as a Patient Safety Issue

A new study surveying 3,562 ED clinicians in 65 hospitals across the nation raises concerns about the safety of critically ill patients. The study, funded by the US Agency for Healthcare Research and Quality, states that, no matter the size or locale, EDs across the country need major improvements in design, management, staffing and support to ensure high-quality patient care in a safe environment.

According to the study's lead author, David Magid, an emergency physician and a senior scientist at the Kaiser Permanente Colorado Institute for Health Research, ED clinicians are reporting widespread problems in four systems that are critical to safety: physician environment, staffing, inpatient coordination and information coordination and consultation. "We found the same problems everywhere," Magid said. He emphasized that hospitals across the country – large, small, academic-based, community-based – can all experience these problems.

While ED overcrowding has been shown in prior studies, Magid said that this study "...was the first to closely examine safety from the perspective of the clinicians who actually work in the emergency department, including physicians and nurses." In their responses, 25% of the clinicians said their ED is too small, 32% said the number of patients exceeds their ED's capacity to provide safe care most of the time, and 50% said their patient capacity is exceeded some of the time. Half of the clinicians reported that ED patients requiring ICU admission are rarely transferred from the ED to the ICU within one hour. Fewer than half said that most specialty consultations for critically ill patients occur within 30 minutes of being contacted.

Part of the problem is that while demand for emergency care has increased by 26% over the past decade, the number of EDs has declined by 9%. EDs "weren't designed to handle the amount of patients that are coming in now," Magid said. He added that when sick patients are put in waiting rooms or hallways, the ED staff may not be able to adequately monitor them. In addition, when patient demand exceeds staff capacity, clinicians may give rushed evaluations or improper treatment in an attempt to provide care to everyone.

One solution the study's researchers recommended was to redesign ED space to make care available to more patients and to increase staffing during busy times. Other recommendations included improving information sharing between clinicians and providing more computer stations for better access to electronic health records. The researchers also said that overall investment in EDs is a key factor. "The requirement for resources to accomplish these changes suggests that third-party players, including government, will have to be involved in any coordinated strategy to address deficiencies in the safety of ED care."

Magid said he is not sure what impact his study will have since ED overcrowding is widely known and yet persistent. He emphasized that people are working on the problem, but increased efforts and new solutions are needed. "Hopefully, results of studies like ours, which go beyond merely showing that the ED is crowded to showing the impact crowding is having on safety issues, might motivate people to do more."

Disparate Screening Claim in Commonwealth of Puerto Rico

On November 13, 2008, the US Court of Appeals for the First Circuit affirmed the Puerto Rico district court grant of summary judgment,

dismissing a claim under EMTALA, that a hospital and physicians did not provide adequate screening in treating a decedent spouse for a fatal coronary condition (*Fratlicelli-Torres v. Hospital Hermanos*, 1st Cir., No. 07-2397, 11/13/08).

The Facts

On June 25, 2003, Guillermo Bonilla Colon, arrived at the Hospital Hermanos Melendez's ED, stating that he had been suffering intermittent severe chest pains and arrhythmia for two days. Following hospital protocols, the ED physicians placed Bonilla on cardiac monitoring, ordered a battery of diagnostic tests and found that he "likely had suffered a myocardial infarction anywhere from nine hours to two days before" presenting at the ED. Determining that the infarction was passed, they did not order any thrombolytic treatment, but admitted Bonilla to the hospital's intensive care unit (ICU) for further observation.

On July 1, hospital physicians conducted a cardiac catheterization, which confirmed a recent myocardial infarction resulting in extensive, irreparable damage to Bonilla's heart muscle. The physicians determined that Bonilla needed to be transferred to another hospital "capable of performing angioplasty or stent implantation." Then two days later, Bonilla began exhibiting symptoms of congestive heart failure. Hospital Hermanos Melendez stabilized Bonilla and with Bonilla's and his wife's informed consent, transferred the patient to another hospital. Bonilla remained at the second hospital until July 14, "when he was transferred to yet another hospital to await heart transplant surgery." Bonilla died two days later of congestive heart failure.

In June 2004, Bonilla's wife Nivia Fraticelli-Torres filed suit against Hospital Hermanos Melendez, its doctors and its insurer, alleging that "defendants had violated EMTALA by treating Bonilla disparately from other similarly situated heart-attack victims." Appellant's EMTALA violations claims included the defendants failure to "subject Bonilla to an adequate cardiac screening examination in accordance with established hospital protocols...to provide Bonilla with adequate medical treatment for his diagnosed heart condition...to immediately transfer Bonilla to another hospital capable of providing the necessary medical care...and to adequately stabilize Bonilla before his July 3 transfer to another hospital." Defendants filed a motion for summary judgment, which was granted by the district court, "finding that appellant had not established a trialworthy EMTALA claim." Fraticelli-Torres appealed the district court decision.

The Ruling

Appellant argued that summary judgment was unwarranted because genuine factual disputes persisted regarding whether "defendants subjected Bonilla to disparate treatment under their established screening/stabilization protocols by refusing to give him thrombolytic treatment" in the ED. The federal appeals court found that Fraticelli-Torres's contentions fell short because "thrombolysis is not a diagnostic tool which would implicate EMTALA's 'screening' criterion, but a treatment option...and therefore, defendants' threshold decision in the ER not to order thrombolysis for Bonilla would implicate only the 'stabilization' criterion."

Fratlicelli-Torres also argued that summary judgment was unwarranted because her husband's myocardial infarction was not a completed event, but continued throughout his one week hospital stay. The ongoing myocardial infarction, according to appellant, thus generated a genuine factual dispute – of whether defendants failed

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to adequately stabilize Bonilla before transferring the patient to another hospital on July 3 – precluding any summary disposition of her EMTALA claim.

The federal appeals court stated that this argument also failed because appellants did not provide any evidence that defendants disparately treated Bonilla. “For EMTALA purposes,” wrote the court, “defendants properly initiated an extensive protocol...and the inferences which defendants drew from Bonilla’s test results might have been faulty or even negligent, but while these matters legitimately might form the grist of appellant’s state-law medical malpractice claim, they normally will not trigger EMTALA liability.”

Appellant next argued that summary judgment was not warranted because EMTALA imposes on a hospital, which cannot provide necessary treatments, the obligation promptly to transfer the patient to a hospital that can do so, “and thus defendants should have ordered

Bonilla’s transfer one week earlier than they did.” Again the court found the appellant’s contention insufficient because, by the time Bonilla was transferred, there was no evidence that the patient was unstable. “By its express terms, EMTALA – which is solely an “anti-dumping” statute – does not impose any positive obligation on a covered hospital to transfer a critical patient under particular circumstances to obtain stabilization at another hospital. Rather, EMTALA merely restricts the conditions under which a hospital may transfer an unstabilized critical patient.”

For these reasons, the US Court of Appeals concluded that the district court properly granted summary judgment and determined that the proper venue for pursuing a medical malpractice claim is in the commonwealth courts of Puerto Rico.

To read the court decision, go to <http://op.bna.com/hl.nsf/r?Open=psts-7lgn7e>

President’s Message - continued from page 1

eligible ABEM diplomates. Our policies consistently support the proper recognition of board certification and the requirement of such certification for the attainment of fellowship status within our Academy.

In conclusion, AAEM does not take a position on who should work in every emergency department, but we strongly support the process of legitimate board certification. This process requires residency training in emergency medicine, similar to the requirements of all legitimate primary specialty boards. In the United States, we only recognize ABEM and AOBEM diplomates as “board certified” in emergency medicine. To act otherwise would only undermine the academic legitimacy of emergency

medicine. For that reason, legitimate board certification in emergency medicine will always be a requirement for fellowship status in AAEM, and we will continue our advocacy in defense of the academic integrity of emergency medicine. You may proudly list the title of FAAEM after your name, identifying you as a board certified specialist in emergency medicine and as a member of the organization in emergency medicine that advocates for the academic integrity of our specialty.

1. *Daniel et al v. ABEM et al.*, 428 F.3d 408 (2nd Cir. 2005).
2. Unless noted otherwise, references to ABEM also apply to the American Osteopathic Board of Emergency Medicine (AOBEM) and the Royal College of Physicians and Surgeons of Canada (RCPSC).

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